

Agency Name &
Phone Number

Stroke and CVD Risk Screening Form



Please fill out the following information:

Sex: ☐ Male ☐ Female Age _____ Screening Location _____
Race/Ethnicity: ☐ African-American ☐ Hispanic ☐ Middle Eastern ☐ Caucasian ☐ Other _____

Please answer the questions below with either "yes or no." (* indicates risk factors with borderline high cholesterol)

Personal History: I have a history of coronary heart disease, heart attack, pulse irregularity, angina, stroke, carotid artery disease **or** TIA (mini-stroke).

☐ NO ☐

YES*

Family History: My father or brother had a heart attack before age 55 **or** my mother or sister had one before age 65; **or** my mother, father, sister, brother or grandparent had a stroke.

☐ NO ☐ YES*

Blood Pressure: I have high blood pressure (140 systolic and/or 90 diastolic or higher), am on medication for high blood pressure.

☐ NO ☐ YES*

Age and Gender: I am a man over 45 years old **or** I am a woman over 55 years old **or** have passed menopause **or** had my ovaries removed.

☐ NO ☐ YES*

Total Cholesterol: I have high total cholesterol (240 mg/dl or higher), am on medication **or** a special diet for my cholesterol.

☐ NO ☐ YES

Diabetes: I have diabetes (a fasting blood sugar of 126 mg/dl or higher) **or** need medicine to control my blood sugar.

☐ NO ☐ YES*

HDL Cholesterol: I have an HDL that is less than 40 mg/dl.

☐ NO

☐ YES*

Overweight: I am 20 pounds **or** more overweight for my height and build.

☐ NO ☐ YES

Tobacco: I currently smoke **or** live or work with people who smoke every day.

☐ NO ☐

YES*

Physical Activity: I get less than a total of 30 minutes of physical activity on most days.

☐ NO ☐ YES

RELEASE: By providing the foregoing information I represent that I understand and agree to the following: The information provided on this form is, to the best of my knowledge, complete and correct. Participation in this program may include taking a personal and family medical history, blood pressure readings, pulse rhythm check, cholesterol and or blood sugar tests; referring me to my health care provider and follow-up consultation. A low risk assessment is not a guarantee of good health, and participation in this program cannot substitute for consultation with a health care provider for any medical or health-related condition, or for regular physical examinations. I release and agree to hold harmless, the agency that is conducting or participating in this program, and any sponsors, their officers, directors, employees, agents, volunteers and representatives from any claims, liability or damages, including but not limited to personal injury or illness, arising in any way from my participation in this program. All medical information obtained in this program will be kept confidential and used by the agency for data collection and reporting in aggregate format.

Signature _____ Date _____
Print Name _____ Phone () _____ Witness _____

***** STAFF USE ONLY *****

TEST	RESULTS	RECOMMENDED RANGES	REFERRAL LEVELS	REFERRED?
BP	<input type="checkbox"/> On treatment now? 1 st _____ / _____ 2 nd _____ / _____ 3 rd _____ / _____	Ideal: Less than 120 systolic & Less than 80 diastolic	<input type="checkbox"/> High: 140-179 systolic or 90-109 diastolic <input type="checkbox"/> Urgent: 180-209 systolic or 110-119 diastolic <input type="checkbox"/> Emergency: 210 + systolic or 120 + diastolic Prehypertensive: 120-139 systolic & 80-89	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pulse Rhythm	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	If irregular, it can increase the risk of a stroke.	Advise to see health care provider if irregular and is a new finding.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chol. Total	<input type="checkbox"/> On treatment now? _____ mg/dl	Total: Less than 200 mg/dl	Total: <input type="checkbox"/> High: 240 mg/dl or greater <input type="checkbox"/> Borderline High: 200-239 mg/dl. Refer if CHD history, diabetes or 2 or more risk factors(*)	<input type="checkbox"/> No <input type="checkbox"/> Yes
HDL	_____ mg/dl analyzer # _____	HDL: 40 mg/dl or greater 60 mg/dl or greater is <i>very desirable</i>	HDL: <input type="checkbox"/> 39 mg/dl or less	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blood Sugar	<input type="checkbox"/> On treatment now? _____ mg/dl	Fasting: Less than 110 Nonfasting: Less than 140	<input type="checkbox"/> High fasting: 110 mg/dl or greater <input type="checkbox"/> High nonfasting: 140 mg/dl or greater	<input type="checkbox"/> No <input type="checkbox"/> Yes

ADVICE:

- ☐ See your doctor for further evaluation 1) ☐ within _____ days; 2) ☐ within the next few months; 3) ☐ at your next visit
FOR ☐ blood pressure ☐ cholesterol ☐ blood sugar ☐ pulse rhythm ☐ other _____
To reduce your risks for cardiovascular disease consider making the following changes:
☐ quit smoking ☐ lose weight ☐ follow the DASH diet ☐ follow a low-fat diet ☐ become more active

Other: _____

Screener name: _____

Participant's Copy